DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13026A (Rev. 04/02)

BADGERCARE PREMIUM
RECIPIENT / EMPLOYER ELECTRONIC FUNDS TRANSFER
INFORMATION AND INSTRUCTIONS

The Wisconsin Medicaid Purchase Plan requires information to enable BadgerCare to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4] Wis. Admin. Code).

Under s .49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as payment of premiums by recipients. Failure to supply the information requested by the form may result in denial of Medicaid payment for services.

INSTRUCTIONS: This form may be used by recipients who are making their own payments, as well as employers who are withholding payments on behalf of employees who have BadgerCare.

Fill out this form for BadgerCare to automatically deduct funds from the checking or savings account the third of each month for the BadgerCare premium payment. Should the third fall on a weekend or holiday, funds will be taken from the account the following business day. To have funds taken out automatically, fill out the section of the form that says “Complete the information below.” Employers must complete a separate form for each employee.

- **Receiving Bank / Savings and Loan / Credit Union**
  Enter the name of the bank, savings and loan, or credit union in the space. If it is a branch office, enter that information under “Branch.” Include the city, state, and Zip code where the bank, savings and loan, or credit union is located. Use the information for the branch visited most frequently.

- **Account Type**
  Check the box for the type of account, checking or savings, from which the funds should be taken.

- **Bank Transit Routing Number and Bank Account Number**
  These numbers can be found on the bottom of your checks and deposit slips. **A voided check or deposit slip must be attached to the Electronic Funds Transfer (EFT) form.** The bank transit routing number is the first nine digits. The following number, up to 17 digits in length, is the bank account number. Contact the bank, savings and loan, or credit union to clarify these numbers.

- **Employer Signature if Applicable**
  If the recipient decides to pay the premium payment using employer wage withholding, and the employer chooses to pay using EFT, the employer will need to fill out and sign the EFT form.

- **Names(s) and Signature(s)**
  Print the name of the account’s owner, and the name of the account’s co-owner if it is a joint account. Next, fill in the Medicaid identification number of the person who is the case head, or the person in charge of MAPP for the family.

The account owner and account co-owner, if it is a joint account, then need to sign and date the form.

If there are any questions regarding the above information, call 1-888-907-4455.

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INSTRUCTIONS: Type or print clearly. Before completing this form, read the information and instructions on the reverse side of this form. **A voided check or deposit slip must be attached to this form for verification of correct information.**

Name(s) on Account

BadgerCare

I give permission to the Wisconsin BadgerCare Program to begin taking money out of my (our) checking/savings account named below, at the bank/savings and loan/credit union named below.

Complete the information below.

Receiving Bank / Savings and Loan / Credit Union	Branch

City of Bank / Savings and Loan / Credit Union	State	Zip Code

Account Type: ☐ Checking ☐ Savings

Bank Transit Routing Number (nine-digit number)

Bank Account Number (maximum 17 digits)

This permission is to remain in effect until BadgerCare has received written notice from me (either of us) of its ending, in order to allow BadgerCare and Firstar Bank a reasonable opportunity to act on it. If I lose my BadgerCare eligibility, I understand my Electronic Funds Transfer will be ended.

Name — Account Owner	Medicaid Identification Number — Case Head

SIGNATURE — Account Owner	Date Signed

SIGNATURE — Account Co-owner (if applicable)	Date Signed

SIGNATURE — Employer (if applicable)	Date Signed

All written debt authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

DISTRIBUTION: Mail completed form to:

BadgerCare Cash/Premium Unit
PO Box 6648
Madison WI 53716-0648
Telephone: 1-888-907-4455
Fax: 1-608-251-1513

Reset Form